



## Division of Behavioral Health Services

Office of Human Rights  
1800 S. Milton Rd., Suite 15  
Flagstaff, Arizona 86001  
(928) 214-8231 or 214-8239  
(928) 214-8246 FAX

Internet: [www.hs.state.az.us/bhs](http://www.hs.state.az.us/bhs)

JANET NAPOLITANO, GOVERNOR

CATHERINE R. EDEN, DIRECTOR

### AUTHORIZATION FOR RELEASE OF INFORMATION

I \_\_\_\_\_  
Consumer's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Hereby authorize \_\_\_\_\_  
Address \_\_\_\_\_

To release the information described below to:

Person and Agency \_\_\_\_\_  
Address \_\_\_\_\_

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Psychiatric Assessments/Evaluations | <input type="checkbox"/> Psychosocial History    | <input type="checkbox"/> Medications       |
| <input type="checkbox"/> Diagnosis/Prognosis                 | <input type="checkbox"/> Treatment/Service Plans | <input type="checkbox"/> Test Results/Labs |
| <input type="checkbox"/> Triage/Discharge Summary            | <input type="checkbox"/> School Records          | <input type="checkbox"/> Team Staffings    |
| <input type="checkbox"/> Progress Notes                      | <input type="checkbox"/> Verbal Communications   |  |
| <input type="checkbox"/> Other _____                         |  |  |

☐ Information from the following facilities (Specify agency name and information needed): \_\_\_\_\_

to include records on drug abuse, alcoholism, sickle cell anemia, human immunodeficiency virus (HIV) infection, acquired immunodeficiency syndrome (AIDS), or tests for HIV information.

Purpose for disclosure: \_\_\_\_\_

I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken. This consent will expire automatically six months from the date on which it is signed (or 60 days with respect to drug and alcohol abuse records). Any disclosure of medical record information by the recipient(s) is not authorized except when implicit in the purposes of the disclosure.

\_\_\_\_\_  
Signature of Consumer (or parent/guardian)

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Other required signature (if applicable)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Consumer

If consumer is a minor and the information requested relates to substance abuse records, his/her signature is required with the signature of parent/legal guardian.

Notice to Recipient: This information has been disclosed to you from records whose confidentiality is protected by Federal law. Federal regulations (42CFR Part 2) prohibits you from making any further disclosure of it without this specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

\_\_\_\_\_  
Consumer Name

\_\_\_\_\_  
Consumer ID